102D CONGRESS
2d Session
HOUSE OF REPRESENTATIVES
REPORT
102-494

WAIVING CERTAIN MEDICAID PROGRAM REQUIREMENTS FOR CERTAIN HEALTH MAINTENANCE ORGANIZATIONS IN DAYTON, OHIO, AND SURROUNDING AREAS

APRIL 9, 1992.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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Mr. DINGELL, from the Committee on Energy and Commerce, submitted the following

REPORT

[To accompany H.R. 4572]

[Including cost estimate of the Congressional Budget Office]

The Committee on Energy and Commerce, to whom was referred the bill (H.R. 4572) to direct the Secretary of Health and Human Services to waive certain requirements under the medicaid program during 1992 and 1993 for health maintenance organizations operated by the Dayton Area Health Plan in Dayton, Ohio, having considered the same, report favorably thereon with amendments and recommend that the bill as amended do pass.

CONTENTS

The amendments are as follows:

Strike out all after the enacting clause and insert in lieu thereof the following:

SECTION 1. APPLICABILITY OF ENROLLMENT MIX REQUIREMENT TO CERTAIN HEALTH MAINTENANCE ORGANIZATIONS PROVIDING SERVICES UNDER DAYTON AREA HEALTH PLAN.

(a) HEALTH PLAN NETWORK.—With respect to the unincorporated associated affiliated with the Dayton Area Health Plan, Inc., that is known as the Health Plan Network, the Secretary of Health and Human Services (hereafter referred to as the "Secretary") shall waive the requirement described in section 1903(m)(2)(A)(ii) of the Social Security Act for the period described in section 2.

(b) DAYMED, INC.—

(1) IN GENERAL.—Subject to paragraph (2), for purposes of determining the compliance of the DAYMED Health Maintenance Plan, Inc., with the requirement described in section 1903(m)(2)(A)(ii) of the Social Security Act for the period described in section 2, the Secretary may not treat individuals enrolled with the Plan who are described in section 1902(1)(1)(D) of such Act as individuals enrolled with the Plan on a prepaid basis.

(2) LIMITATION ON NUMBER OF INDIVIDUALS EXEMPTED.—The number of individuals enrolled with the DAYMED Health Maintenance Plan, Inc., whom the Secretary may not treat as individuals enrolled with the Plan on a prepaid basis pursuant to paragraph (1) may not exceed 4,000.

SEC. 2. PERIOD OF APPLICABILITY.

The period referred to in subsections (a) and (b)(1) of section 1 is the period that begins on May 1, 1992, and ends on January 31, 1994.

Amend the title so as to read:

A bill to direct the Secretary of Health and Human Services to grant a waiver of the requirement limiting the maximum number of individuals enrolled with a health maintenance organization who may be beneficiaries under the medicare or medicaid programs in order to enable the Dayton Area Health Plan, Inc., to continue to provide services through January 1994 to individuals residing in Montgomery County, Ohio, who are enrolled under a State plan for medical assistance under title XIX of the Social Security Act.

PURPOSE AND SUMMARY

The purpose of H.R. 4572 is to provide temporary relief from the enrollment mix requirement of current Medicaid law to certain health maintenance organizations associated with the Dayton Area Health Plan, operating in Montgomery County, Ohio. This relief would extend from May 1, 1992, through January 31, 1994, and would apply only to Health Plan Network and DAYMED Health Maintenance Plan, Inc.

BACKGROUND AND NEED FOR THE LEGISLATION

Current law

Medicaid is a Federal-State, means-tested entitlement program that purchases basic medical care and long-term care services on behalf of 30 million poor people. The Federal government matches State expenditures for covered services on behalf of eligible individuals; the Federal contribution varies inversely with the State's per capita income. In the case of Ohio, the Federal matching rate in FY 92 is 60.6 percent; that is, the Federal government pays three fifths of the cost of providing hospital, physician, and other basic health services to the poor in Ohio. In order to receive Federal matching payments, States must meet requirements set forth in Federal Medicaid law.

Under current law, States may contract on a risk basis with health maintenance organizations to provide hospital, physician, and other basic health services to Medicaid beneficiaries. Federal matching funds are not available for payments made under these contracts unless certain requirements are met. One of these,

known as the 75/25 rule, requires that at least 25 percent of the individuals enrolled on a prepaid basis in the contracting HMO not be insured under Medicare or eligible for Medicaid. This requirement does not apply for the first 3 years that an entity contracts with a State Medicaid program as an HMO, so long as the entity demonstrates to the satisfaction of the Secretary by the submission of plans for each year of the 3-year period that it is making continuous efforts and progress toward achieving compliance with the 75/25 rules.

The purpose of the 75/25 rule is to assure that Federal Medicaid matching funds are being used to purchase care of adequate quality. Under risk-based contracts, in which the contractor is receiving a fixed amount per month for each individual enrolled regardless of that individual's actual use of services, there exists a financial incentive for the HMO or other contractor to provide fewer services. To protect Medicaid beneficiaries against this potential underservicing, Federal law requires that, after 3 years, at least 1 out of 4 individuals enrolled on a prepaid basis be individuals who are not Medicaid or Medicare beneficiaries. If significant numbers of employees (and dependents) of public or private employers are willing to enroll in—and stay enrolled in—the HMO, then the Federal government can have some assurance that the quality of care is likely to be adequate.

One consequence of the 75/25 rule may be to restrict the development of HMOs or other prepaid plans that enroll only Medicaid beneficiaries but still deliver care of demonstrably high quality. However, Title XIX does not include quality assurance standards or processes for evaluating Medicaid managed care.

Dayton area health plan

The Dayton Area Health Plan is a mandatory enrollment program for approximately 42,600 Aid to Families with Dependent Children (AFDC) recipients in Montgomery County, Ohio. Under the Plan, AFDC recipients may not receive Medicaid benefits on a fee-for-service basis; instead, they are limited to enrolling in one of three HMOs: Health Plan Network, DAYMED Health Maintenance Plan, Inc., and Health Power of Dayton. The State of Ohio makes capitation payments to the Dayton Area Health Plan, an Ohio not-for-profit corporation, which in turn disburses payments to each of the 3 participating HMOs based on their monthly Medicaid enrollment. Health Plan Network is the registered trade appellation for the Dayton Area Health Plan insofar as it operates as an HMO providing health care to the Medicaid and General Relief population of Montgomery County that are not enrolled in DAYMED or Health Power.

The Plan operates under waivers granted by the Secretary of Health and Human Services with respect to the following Medicaid requirements: freedom of choice of provider (section 1902(a)(23) of the Social Security Act); statewideness (section 1902(a)(1)); comparability in amount, duration, and scope of services (section 1902(a)(10)); and payment consistency with efficiency, economy, and quality of care (section 1902(a)(30)). These waivers are granted under the authority of sections 1915 (b)(1) and (b)(2) of the Social Security Act, which authorize the Secretary to grant waivers to

States to enable them to require enrollment by Medicaid beneficiaries in a primary care case management system or a central brokerage arrangement. These waivers were initially granted for 2 years effective August 1, 1988, and subsequently continued through January 31, 1994. Under the terms of these waivers, the Plan must continue to be cost-effective, must not substantially impair access to care and services of adequate quality, must provide case-managed health care to enrolled beneficiaries, and must not restrict access to emergency care or family planning services.

The Committee is informed by the Health Care Financing Administration that, under an unwritten HCFA policy interpretation, the waivers under which the Plan is currently operating are contingent upon Medicaid beneficiaries having a choice of enrolling in at least two HMOs, both of which are in compliance with Federal statutory requirements, including the 75/25 enrollment mix rule. According to HCFA, the exemption of Health Plan Network from this requirement will expire on April 30, 1992, and the Secretary is not authorized to exempt Health Plan Network or either of the other two participating HMOs from this requirement. (The only exception is the demonstration waiver authority under section 1115 of the Social Security Act, which is not apposite here).

According to the State of Ohio, as of April 7, 1992, the enrollment composition of each HMO participating in the Dayton Area Health Plan was as follows:

	Health Plan Network		DAYMED		Health Power/Dayton	
	Number	Percent	Number	Percent	Number	Percent
Medicaid	22,994	89.6	13,369	66.0	5,775	75.5
Commercial	2,680	10.4	7,144	34.0	1,876	24.5
Total	25,674		21,013		7,651	

Clearly, the Health Plan Network will not meet the 75/25 enrollment composition requirement as of April 30, 1992. Without compliance, the waivers now in effect for the Dayton Area Health Plan will, under HCFA's interpretation, expire on that date.

The Committee has enabled the waivers currently in effect for the Dayton Area Health Plan to continue with the understanding that the Plan will meet the terms and conditions of the waivers regarding access to care and services of adequate quality. To enable those waivers to continue until January 31, 1994, the Committee bill would alter the application of the 75/25 rule with respect to two of the HMOs currently participating in the Plan.

With respect to the Health Plan Network, the Committee bill would direct the Secretary to waive the 75/25 rule from May 1, 1992, through January 31, 1994. The Committee bill would not authorize or direct the Secretary to waive this requirement with respect to DAYMED Health Maintenance Plan, Inc., or Health Power of Dayton.

Instead, the Committee bill would provide that, in determining whether DAYMED meets the 75/25 requirement, the Secretary could not count children who are eligible for Medicaid because they are born after September 30, 1983, and are in families with in-

comes at or below the Federal poverty level. Up to 4,000 of these poverty level-related children could be enrolled on a prepaid basis in DAYMED without being counted either as Medicaid beneficiaries or commercial enrollees for purposes of the 75/25 rule. Any such children in excess of 4,000 would be counted as Medicaid-eligible for purposes of the enrollment mix requirement. For example, if DAYMED's commercial enrollment were to fall from the current level of 7,144 to 2,500, it would have to reduce its AFDC enrollment from 13,869 to 7,500 in order for the State of Ohio to continue to receive Federal matching funds for payments made to DAYMED. If DAYMED were to enroll 4,250 poverty level children, it would either have increase its commercial enrollment by 750 individuals or reduce its Medicaid enrollment by 250 in order to remain in compliance.

The Committee notes that, under the terms of the Agreed Judgment Entry in *Oglesby* v. *Barry*, No. C-3-89-125 (S.D. Ohio, Jan. 12, 1990), the Dayton Area Health Plan and Health Plan Network are prohibited, effective May 1, 1992, from counting General Assistance recipients or any other public assistance recipients as enrollees who are not eligible for Medicaid or Medicare for purposes of determining compliance with the 75/25 enrollment composition requirement. Under the Committee bill, the 75/25 rule would be waived with respect to Health Plan Network for the period May 1, 1992 through January 31, 1994; thus, this term of the Agreed Judgment Entry in *Oglesby* would not be relevant to Health Plan Network's enrollment mix for that period. However, with respect to the other two HMOs participating in the Dayton Area Health Plan, the 75/25 rule would continue to apply. In such application, the Committee bill does not, and the Committee does not intend to, alter the terms of the Agreed Judgment Entry with respect to the counting of General Assistance or other public assistance enrollees for purposes of determining compliance with the 75/25 rule.

SECTION-BY-SECTION ANALYSIS AND DISCUSSION

Section 1. Applicability of enrollment mix requirement

(a) Health Plan Network: The Committee bill would direct the Secretary of Health and Human Services to waive the enrollment mix requirement described in section 1903(m)(2)(A)(ii) of the Social Security Act with respect to Health Plan Network, the unincorporated association affiliated with the Dayton Area Health Plan, Inc., for the period described in section 2. (Section 1903(m)(2)(A)(ii) requires that at least 25 percent of the individuals enrolled on a prepaid basis in an HMO contracting with the Medicaid program be individuals who are not insured under Medicare or eligible for Medicaid). This waiver would not apply to DAYMED Health Maintenance Plan, Inc., or to Health Power of Dayton, which would both continue to be subject to the 75/25 enrollment mix requirement.

(b) DAYMED: The Committee bill would provide that, for purposes of determining the compliance of the DAYMED Health Maintenance Plan, Inc., with the 75/25 enrollment mix requirement during the period described in section 2, the Secretary may not include individuals enrolled with the Plan who are described in sec-

tion 1902(l)(1)(D) of the Social Security Act (i.e., children born after September 30, 1983, in families with incomes at or below 100 percent of the Federal poverty level) in either the numerator or the denominator when computing DAYMED Inc.'s enrollment mix. The exclusion of this category of poverty level-related children for purposes of this computation would apply to no more than 4,000 of such children. Any children in this category in excess of 4,000 who are enrolled in DAYMED, Inc., would be counted as individuals eligible to receive benefits under Title XIX for purposes of determining compliance with the 75/25 enrollment mix requirement.

Section 2. Period of applicability

The period to which the provisions of section 1 would be applicable is May 1, 1992, through January 31, 1994.

HEARINGS

No hearings were held on this legislation.

COMMITTEE CONSIDERATION

The bill H.R. 4572 was introduced on March 25, 1992 by Mr. Hall of Ohio (for himself, Mr. Hobson, Ms. Oakar, Mr. Oxley, Mr. Luken, Mr. Traficant, Mr. McEwen, and Mr. Eckart). It was referred exclusively to the Committee on Energy and Commerce.

On April 7, 1992, the Committee met in open session. Pursuant to a unanimous consent request by the Chairman of the Subcommittee on Health and the Environment, the Subcommittee was discharged from consideration of the bill. The Committee then took up the bill, H.R. 4572, and ordered it reported, with amendment, by a voice vote, a quorum being present.

COMMITTEE OVERSIGHT FINDINGS

Pursuant to clause (2)(l)(3)(A) of rule XI of the Rules of the House of Representatives, the Subcommittee on Health and the Environment has made no oversight findings on the operation of the Dayton Area Health Plan, Inc.

COMMITTEE ON GOVERNMENT OPERATIONS

Pursuant to clause 2(l)(3)(D) of rule XI of the Rules of the House of Representatives, no oversight findings on the subject of the Dayton Area Health Plan, Inc., have been submitted to the Committee by the Committee on Government Operations.

COMMITTEE COST ESTIMATE

In compliance with clause 7(a) of rule XIII of the Rules of the House of Representatives, the Committee agrees with the Congressional Budget Office that no cost would be incurred by the Federal Government in carrying out H.R. 4572 in fiscal year 1992 or in fiscal years 1993 through 1997.

INFLATIONARY IMPACT STATEMENT

Pursuant to clause 2(l)(4) of rule XI of the Rules of the House of Representatives, the Committee states that the enactment of this

bill into law will not have an inflationary impact on prices and costs in the operation of the national economy. The bill affects only the delivery of basic health care services on a prepaid basis to approximately 42,500 low-income women and children residing in Montgomery County, Ohio.

CONGRESSIONAL BUDGET OFFICE ESTIMATE

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, April 8, 1992.

Hon. JOHN D. DINGELL,
Chairman, Committee on Energy and Commerce,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 4572, as ordered reported by the House Committee on Energy and Commerce on April 7, 1992. H.R. 4572 would direct the Secretary of Health and Human Services to waive certain requirements under the Medicaid program for health maintenance organizations operated by the Dayton Area Health Plan in Dayton, Ohio. Enactment of H.R. 4572 could affect Medicaid spending, which is considered direct spending and is subject to pay-as-you-go procedures. We have enclosed the estimate required by clause 8 of House Rule XXI.

If you wish further details on this estimate, we will be pleased to provide them.

Sincerely,

ROBERT D. REISCHAUER.

Enclosure.

CONGRESSIONAL BUDGET OFFICE—COST ESTIMATE

1. Bill number: H.R. 4572
2. Bill title: None
3. Bill status: As ordered reported by the House Committee on Energy and Commerce on April 7, 1992.
4. Bill purpose: To direct the Secretary of Health and Human Services to waive certain requirements under the Medicaid program for health maintenance organizations operated by the Dayton Area Health Plan in Dayton, Ohio.
5. Estimated cost to the Federal Government:

[By fiscal years, in millions of dollars]

	1992	1993	1994	1995	1996	1997
Direct spending:						
Estimated budget authority	0	0	0			
Estimated outlays	0	0	0			
Total	0	0	0			

The costs of this bill fall within budget function 550.

Basis of Estimate: Section 1902 of the Social Security Act requires all Medicaid health maintenance organizations (HMOs) to maintain an enrollment that is composed of at least 25 percent of

privately insured enrollees. This enrollment composition requirement is meant to guarantee a level of quality for Medicaid beneficiaries that is similar to the level demanded by privately insured individuals.

This bill would waive the enrollment composition requirement for one Medicaid health maintenance organization operated by the Dayton Area Health Plan and would specify that certain Medicaid enrollees would not be included as publicly insured patients in another Dayton Area HMO for the purpose of determining compliance with the enrollment composition requirement. Waiving the enrollment composition requirement would allow the above HMOs to continue operating as qualified Medicaid HMOs. If the HMOs provide services at a lower cost to the Medicaid program than other Dayton area providers, the waiver could result in savings. On the other hand, if the HMOs provide services at a higher cost than other providers, then the waiver's effect would be an additional cost to the federal government. There is little information available on the relative cost of Medicaid services among Dayton Area providers. CBO assumes the net effect of the waiver would be zero.

The waiver would be in effect from May 1, 1992 through January 31, 1994.

6. Pay-as-you-go considerations: Enactment of H.R. 4572 could affect Medicaid spending, which is considered direct spending and is subject to pay-as-you-go procedures. The estimate required by clause 8 of House Rule XXI is attached.

7. Estimated cost to State and local government: None.

8. Estimate comparison: None.

9. Previous CBO estimate: None.

10. Estimate prepared by: Jean Hearne.

11. Estimate approved by: C.G. Nuckols, Assistant Director for Budget Analysis.

CONGRESSIONAL BUDGET OFFICE ESTIMATE [1]

The applicable cost estimate of this Act for all purposes of sections 252 and 253 of the Balanced Budget and Emergency Deficit Control Act of 1985 shall be as follows:

[By fiscal years, in millions of dollars]

	1992	1993	1994	1995
Change in outlays	0	0	0	0
Change in receipts	(1)	(1)	(1)	(1)

[1] Not applicable.

AGENCY VIEWS

No views were received from the Department of Health and Human Services or the Office of Management and Budget.

[1] An estimate of H.R. 4572, as reported by the House Committee on Energy and Commerce on April 7, 1992.

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